Smoking Cessation During Pregnancy: Guidelines for Intervention

Revised Edition 2013

Washington State Tobacco Quitline–
See page 26!

- **ASK**
- **ADVISE**
- **ASSESS**
- **ASSIST**
- **ARRANGE**

Washington State Department of Health

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Information in this booklet comes from the following sources:

- American College of Obstetrics and Gynecology. *Educational Bulletin* 316; October 2005.
- American College of Obstetrics and Gynecology. *Committee Opinion* 471; reaffirmed 2012.
- Arizona Department of Health, Tobacco Education Program. *Basic Tobacco Intervention Skills Certification Guidebook*, 2001.
- United States Department of Health and Human Services, Public Health Service. *Clinical Practice Guideline: Treating Tobacco Use and Dependence*, June 2008.
- Smoke-Free Families. *Need Help Putting Out That Cigarette?*, 2002.
- Smoke-Free Families and American Cancer Society. *A Quitline Protocol for Pregnant Smokers*, 2001.

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Introduction

Reducing tobacco use among pregnant and parenting women is a top public health priority in Washington State. Smoking accounts for 20 to 30 percent of all low birth weight babies born nationwide, and many consider smoking to be the single most important preventable cause of low birth weight. Among infant deaths, 5–7 percent of preterm-related deaths and 23–34 percent of SIDS deaths could be avoided by eliminating smoking during pregnancy.[1]

Besides low birth weight, smoking during pregnancy is associated with maternal and infant morbidity and mortality. Additional risks associated with tobacco use during pregnancy include Sudden Infant Death Syndrome, preterm birth, ectopic pregnancy, miscarriage, placenta previa and abruption, intrauterine growth restriction, and other complications.[2] Newer research indicates increased risk of oral cleft defect and modest risk for congenital heart defect.[3]

In 2011, about 9 percent of pregnant women reported smoking during the last three months of their pregnancy compared to 15 percent of pregnant women on Medicaid. While many women quit or reduce smoking during pregnancy, relapse after birth is high. In 2011, 13 percent of women reported smoking in postpartum compared to 20 percent of women on Medicaid.[4]

According to the United States Public Health Service Guidelines, an office-based protocol that systematically identifies pregnant smokers and provides an intervention has been proven to increase quit rates. Current literature suggests that programs designed specifically for pregnant women and begun early in pregnancy are the most effective. A brief intervention of 5–15 minutes by a trained provider plus appropriate follow-up at future visits and referrals and resource materials will increase cessation for **light to moderate smokers**. Abbreviated intervention of 30 seconds to 3 minutes can also be effective.[5] This has been demonstrated in all racial and ethnic groups. **Heavy smokers** can also benefit from a client centered, non-threatening intervention. The goal of the intervention is to understand the woman's reasons to continue smoking during pregnancy, the importance she places on quitting, and her confidence in being able to succeed. For those pregnant women who are ready to quit, the provider can offer help. For those pregnant women who feel cessation is not a priority, or possible to achieve, a trained provider can share information about why smoking cessation promotes healthier outcomes for the pregnant woman and her baby.

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[1] Dietz, PM, England, LJ, Shapiero-Mendoza, CK, Tong, VT, Farr, SL, Callaghan, WM. (2010). Infant Morbidity and Mortality Attributable to Prenatal Smoking in U.S. *American Journal of Preventive Medicine*, 39(1), 45-52.

[2] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." *ACOG Committee Opinion* 471. Washington, DC: ACOG, reaffirmed 2012.

[3] Alverson, CJ, Strickland, MJ, Gilboa, SM, Curren, A (2011). Maternal Smoking and Congenital Heart Defects in Baltimore – Washington Infant Study. *Pediatrics*, 127(3), 647-652.

[4] Washington State Department of Health, *Perinatal Indicators Report for Washington Residents*, April 2013.

In the May 2008, Treating Tobacco Use and Dependence Clinical Practice Guideline, the US Public Health Service made the following recommendations:

- Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered person-to-person psychosocial interventions that exceed minimal advice to quit.
- Although abstinence early in pregnancy will produce the greatest benefits to the fetus and expectant mother, quitting at any point in pregnancy can yield benefits. Therefore, clinicians should offer effective tobacco dependence interventions to pregnant smokers at the first prenatal visit as well as throughout the course of pregnancy.[6]

The American College of Obstetricians and Gynecologists continues to recommend that clinicians identify pregnant women who smoke and offer the brief intervention.[2]

The purpose of this booklet is to provide clinicians with information about how to conduct this type of brief intervention with pregnant women, offer resources for pregnant women who want to quit, and provide information about the use and prescription of smoking cessation pharmaceutical aids during pregnancy. Although many specific suggestions are made in this booklet, the details of what you do are less important than the routine and systematic use of clinical skills and office systems to help pregnant women quit.

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[5] US Department of Health and Human Services, Public Health Service. *Treating Tobacco Use and Dependence: 2008 Update.*

[6] Melvin C, Dolan-Mullen P, Windsor R, Whiteside HP, and Goldberg, RL. "Recommended Cessation Counseling for Pregnant Women Who Smoke: A Review of the Evidence." *Tobacco Control, Suppl III, Vol 9,* iii 80-84, 2000.

Implementation in Your Practice Setting[7]

How you implement smoking cessation into your practice setting can influence your success. Here are some tips from The American College of Obstetricians and Gynecologists:

Develop administrative commitment – Every staff member has an important role to play and to be effective, screening and intervention should be supported by all. Make sure all staff understand the importance of this program and explain the approach.

Involve staff early in the process – Be sure to include staff in planning and address any concerns they may have about their role and how this may impact workload and flow.

Assign one person to coordinate and monitor implementation – Designate one staff member to oversee this process. This person should coordinate the process, answer questions, and troubleshoot when problems come up. The coordinator can evaluate the process and also identify additional resources for staff and patients.

Provide training – Staff should be trained in the brief intervention that will be used and what they are responsible for.

[7] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking. A Self-instruction Tool Kit for Getting your Office Ready." Washington, DC, 2011.

Brief Intervention

Adapted from American College of Obstetricians and Gynecologists 5As Brief Intervention Tool 5[8]

All pregnant women should be systematically screened regarding their smoking status ("Ask"). A brief clinic-based (5–15 minutes) intervention is most effective with pregnant women who **smoke less than 20 cigarettes per day.**[9] Heavier smokers may require more intensive intervention. The brief intervention can be accomplished either completely within your clinic (the "5As"), or can include use of referral resources for comprehensive assistance and follow-up (the "2A&R" model).

ASK

Unlike most adult smokers, pregnant women tend to under-report smoking. Research has shown that the use of multiple choice questions as opposed to simple yes/no question, can increase disclosure by as much as 40 percent.

For example, you can ask the patient to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.

B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.

C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.

D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.

E. I smoke regularly now, about the same as BEFORE I found out I was pregnant.

You can incorporate these questions into written forms used during the office intake process.

If the patient has never smoked or has smoked very little (A), acknowledge this wise choice and assess the need to ask about secondhand smoke exposure. If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and beyond postpartum.

If the patient is still smoking (D or E), document smoking status in the medical chart, and proceed to Advise, Assess, Assist, and Arrange.

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[8] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." *ACOG Educational Bulletin,* No 316. Washington, DC: ACOG, 2005.

[9] Melvin C, Dolan-Mullen P, Windsor R, Whiteside HP, and Goldberg, RL. "Recommended Cessation Counseling for Pregnant Women Who Smoke: A Review of the Evidence." *Tobacco Control*, Suppl III, Vol 9, iii 80-84, 2000.

ADVISE

Ask the client to tell you what she knows about smoking during pregnancy. Provide clear advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus. Be sure you deliver the message in an empathetic manner, rather than a judgemental manner.

> ***"Quitting smoking lessens your risk for miscarriage, preterm delivery, and stillbirth. Your baby starts getting more oxygen after just one day of not smoking."***

ASSESS

Before assessing the woman's readiness to quit, consider asking the woman what she thinks of the health message you shared with her about smoking during pregnancy. Does she have any questions? Then assess the willingness of the patient to attempt to quit.

> ***"Quitting smoking is one of the most important things you can do for your health and for your baby's health. Are you willing to try quitting? What kind of support do you need from us to help you succeed?"***

If the patient is ready to quit, proceed to Assist.

If the patient is not ready, explore her reluctance, including questions such as "is there anything that might make you willing to try to quit?" If she remains unwilling to quit, proceed to Arrange.

ASSIST

Briefly explore problem-solving methods and skills for smoking cessation, i.e. "Have you tried quitting; what did you try; what do you think might help?"

- Identify "trigger" situations with client.

Discuss social support in her environment.

- Identify her "quit buddy" and her smoke-free space

Provide pregnancy-specific, self-help smoking cessation materials. See Appendix F on page 40.

Assist in developing a quit plan, including a quit day, and document in the medical chart. Refer the client to the tobacco quitline (1-800-QUIT-NOW or 1-855-DEJELO-YA Spanish), and explain the services offered, if interested. Even though not all women are eligible for quitline services, they will be referred to other resources. Consider using the Quitline Fax Referral option to take immediate action. See Appendix C on page 31. The Health Care Authority Medical Program Smoking Cessation Benefit will cover pharmacotherapy and may provide reimbursement for cessation referral. See Appendix A on page 25.

ARRANGE

Before the woman leaves, let her know that you will be checking in to see how she is doing at each visit. Ask her to call if she has questions or concerns.

Assess smoking status at subsequent prenatal visits. If she has quit successfully, strongly reinforce her efforts. If the patient continues to smoke, continue to encourage cessation, and explore barriers to quitting.

Affirm all efforts to change and continue to assist her with her efforts to quit. Document status and assistance in the medical chart.

The 2A & R Brief Intervention

For providers or clinics that do not have the time or resources to conduct a full "5A" intervention, a briefer version called the "2A & R" exists. While it is abbreviated for you, your patients still receive a full intervention. However, in this time of uncertain resources, it is important for Medicaid providers to do the full 5A interventions as not all women will be eligible for quitline services.

ASK about tobacco use:

"How often have you used tobacco in the past 30 days?"

ADVISE the patient to quit:

"Quitting tobacco is one of the best things you can do for your health and the health of your baby. I strongly encourage you to quit. Have you thought about quitting?"

REFER to resources:

If interested in help quitting:

Provide direct referral to a resource that will complete the "Assess, Assist, and Arrange" steps:

"This is a service I recommend. They will provide you with support, create a quit plan, and help you overcome urges."

The quitline is a good example of a resource that will complete the "Assess, Assist and Arrange" steps as outlined in the 5A model if the woman is Medicaid eligible. Other examples of resources may include hospital or community based cessation classes.

Referral resources should be easily accessible, without financial or geographic barriers, convenient, and acceptable to the patient. In addition, the referral resources should have experience working with pregnant women helping them quit smoking. A referral resource that provides feedback to the referring clinician on progress is extremely helpful. See Appendices B, C, and F.

If no:

Provide self-help materials and let patients know you are available for future support:

"When you are ready to quit, I am here to support you and have resources that can assist you."

Be sure and check back in with patients at each visit.

Provider Scripts for Motivating the Client

Cutting Down

If she says no to quitting, but has cut down, or wants to cut down: Smoking is a complex addictive behavior. For heavy smokers who continue to smoke during pregnancy, refused to stop, or have tried but not succeeded, harm reduction strategies are something to consider to help the woman gain confidence that she can succeed in quitting.

Provider prompt: "I understand that you'd like to cut down on your smoking. Quitting smoking is the best thing you can do for both you and your baby. For some people, cutting down can be the first step toward quitting. For others, only quitting works. What do you need to help you cut down as the first step?"

Provider response: Acknowledge her response and plan to change. Ask if she is ready to start cutting back right away. If she wants to start, brainstorm things she can do to occupy her hands (doodle, crafts, rubber band), mouth (gum, straw, hard candy), and mind (distract herself, think of baby). Arrange to call her in a week to see how she's doing. Remind her to use the written materials she has received (or will receive). Continue to assess her readiness to quit.

Preparing to Quit

The first step of your support plan is to work with her to develop an individualized quit plan.

Provider prompt: "How are you feeling about your smoking situation?" How many cigarettes a day are you smoking now?"

Provider response: Acknowledge her feelings. Give heavy reinforcement for desire to quit. Remind her to use her self-help materials. Write down the number of cigarettes she smokes per day and praise her if she has cut down.

If She Has Set a Quit Day

This is a big step and demonstrates her readiness to change her behavior. Encourage her to talk about her concerns, determine the degree of support in her environment, help her identify high risk smoking situations, review her reasons for quitting, and review how she can prepare for the quit day.

Provider prompt for talking about her concerns: "How do you feel about your plans to quit smoking? Do you have any questions or concerns?"

Provider response: Problem-solve with her about perceived problems. Use information in the self-help materials. Remind her that you are available to help and support her as she prepares for this quit attempt. Remind her that quitting smoking is the most important thing she can do for herself and her baby.

Provider prompt for assessing support: "How do you think the people around you feel about your plans to quit (cut down)? Are you around other smokers?"

Provider response: Acknowledge advantages of having support from others and not having smokers around her or problem-solve using the information on page 11. Refer to quitline for support groups.

Provider prompt for identifying high risk situations: "What particular times of the day do you think might be hardest to get through without smoking?"

Provider response: Problem-solve around one high-risk time or situation.

Provider prompt for reviewing reasons to quit: "Last time we talked you mentioned some pretty important personal reasons for quitting (cutting down) (list them for her). Some women like to write those down, stick them on the refrigerator, and look at them when they need to remind themselves why they're doing this. Some women also like to talk to their baby about the reasons. They tell their baby, 'Hey, this is what I'm doing for you.'"

Provider response: Give strong reinforcement for her personal reasons to quit. Encourage her to think of more reasons to quit and ways to achieve this goal.

Preparing a Quit Day Plan

Eighty percent of successful ex-smokers quit "cold turkey" by setting a Quit Day and stopping completely on that day. If the woman has set a Quit Day, suggest the following as ways to prepare:

- Get rid of smoking materials before quitting (totally shred cigarettes to remove temptation, clean out ashtrays, give away lighters and matches, make it hard to access a cigarette).
- Be clear on reasons for quitting (state them and rehearse them regularly).
- Be ready for urges to smoke. Plan some specific things to do when urges occur (see page 12); and find ways to occupy hands, mouth, and mind.
- Ask for help and encouragement from others, preferably ex-smokers who know what you're going through.
- Suggest the Washington State Tobacco Quitline as a resource that is available to her when you may not be available, such as in the moment during a craving.

Quit Day Follow-up Call

Consider having someone from the practice staff make a quit day follow up call. Ask the woman if this would be okay and helpful to her. Make additional support calls between prenatal care visits if this is a possibility in your setting, and agreeable to the client. The quitline is another resource for follow up with the client.

Provider prompt: "Today is your quit day. Are things going as planned?"

Provider prompt: "What kinds of difficulties are you having today?

Provider prompt: "How are you doing with negative feelings, like stress, without smoking?" "Are you having difficulty dealing with others smoking around you?" "Are you having strong urges or cravings for a cigarette?" "Have you noticed any strong withdrawal symptoms?"

Provider response: If she has not quit smoking, but seems to be doing well cutting down, ask if she would be willing to set another quit date.

Provider prompt: "How many cigarettes a day are you smoking now?"

Provider response: Document her response and praise any decrease in smoking.

Provider prompt: "You seem to be doing very well cutting down on your smoking, and smoking fewer cigarettes is better than smoking more cigarettes. As you know, it's best to quit completely. I'm wondering if you'd be willing to set another quit date at this point."

Provider response: If yes, praise her, write down her quit date, and help her prepare to quit.

Praise all women who are attempting to quit and encourage self-care during this stressful process.

Provider prompt: "I know that it's not an easy process to quit smoking (to cut down on the number of cigarettes you smoke), but I think it's great that you're working on it. Can you think of ways you can pamper yourself while you're changing your smoking habit?"

Provider response: Suggest things other women have done to pamper themselves such as shopping, a back rub, telephoning someone she has not talked to in a long time, taking a bubble bath, buying a plant or flowers, going for a relaxing walk, going out for ice cream.

Anticipating and Managing Problems

The problem-solving process is a way to help a woman figure out how to handle situations or feelings that set the stage for smoking. The goal of problem solving is to come up with one or more practical ways to handle a high-risk situation without smoking. Steps to problem solving are listed below.

1. **Clearly define the problem.** Ask the woman to identify as specifically as possible the situation or feeling that created an urge to smoke. Get a clear, concrete, circumscribed definition of the problem such as:
   - I was at a friend's house, and she lit up a cigarette.
   - I had an argument with my husband, and was feeling angry with him.
   - The kids were driving me crazy, and I needed a break.

2. **Develop possible solutions.** Ask the woman to think of several different things she could do to handle the situation or feeling without smoking. Do not evaluate the solutions at this point; simply ask her to come up with as many possibilities as she can. Acknowledge all of her suggestions no matter how unrealistic they may seem.

3. **Add to her list of possible solutions.** Suggest a few of your own solutions. Do not evaluate any solutions yet.

4. **Choose one or two solutions from the list to try.** Go over the list of solutions with the woman and ask her what she thinks would work best for her. If none are practical for her, repeat Steps 2, 3, and 4.

5. **Get agreement to try out the solution.** Ask her if she would be willing to try out the solution the next time she is faced with the problem situation or feeling. Tell her you would like to hear how it worked the next time you talk with her.

Problem #1: Being Around Smokers

Thirty percent of relapses occur when an ex-smoker is around someone smoking. This is a high-risk situation because of the visual and olfactory cues to smoke, and cigarettes are readily available.

Suggested strategies for the client:

- Try to avoid the situation in the first place.
- Ask friends or family members to quit with you.
- Ask others not to smoke around you, now that you are pregnant.
- Recite reasons for quitting.
- Leave the room when others light a cigarette.
- Plan ways to distract yourself when someone else is smoking (least preferred option because you are still in the presence of the cigarette). Find ways to occupy your hands (knit or sew, play with a straw or rubber band, hold a pen or pencil, draw or doodle, squeeze a rubber ball, work on a craft project), your mouth (suck on hard candy, chew gum, use a toothpick or straw, sip water or

juice, try a cinnamon stick, eat some fresh fruit), and your mind (think about the baby or a pleasant activity not involving smoking).

- Caffeine is metabolized more slowly when you quit smoking. The same level of caffeine intake will be equal to double the dose when you quit.

Problem #2: Coping with Negative Feelings

Over 50 percent of relapses occur when an ex-smoker is feeling some sort of negative emotion. It can be a "high energy" negative emotion such as anger, stress, anxiety, or frustration, or it can be a "low energy" negative emotion such as loneliness, boredom, or sadness. Many women perceive that a cigarette helps them cope with the negative emotion. Smoking does not take the negative feeling away completely, but it tempers it slightly, making it less intense. When you stop smoking, you lose that coping strategy, leaving the full force of the negative feelings. The goal is to find ways other than smoking (and drinking) to reduce the negative emotions.

Suggested strategies for the client:

- Take a hard candy break (if clinically appropriate). Sucrose (sugar) seems to have some soothing properties and is a good substitute for having a cigarette when experiencing a negative emotion. Like a cigarette, it is immediate, inexpensive, and portable, and it lasts for several minutes. Hard candies (such as sour balls, lemon drops, life savers, lollipops) that are purely sugar and no fat do not add many calories, but can help to temper a negative emotion.
- Do something physical. Burn up some of the negative energy through physical activity. Take a walk, sweep or vacuum the floor, do some gardening, turn on music and dance.
- Express feelings. The idea is to modulate some of the negative emotions by expressing them. Write down those feelings, say them into a tape recorder, or talk with a friend.
- Relax. Gradually bring down the level of negative energy. Take a hot bath or shower; listen to your favorite soothing music; take ten slow, deep breaths; think about a favorite peaceful place; meditate; or stroke a pet.
- Redirect thoughts. See if you can change your mood by thinking of something that made you feel good, something you accomplished or mastered, or something you enjoyed in the past.
- Build your own support system. Ask others to be aware that this is a difficult time. Prepare them for your irritability and moods, and ask for help in doing some of your routine tasks.

Problem #3: Coping with Urges

Most people get urges for a cigarette after quitting. Urges often occur when doing something associated with smoking. What situations set the stage for having an urge? Examples include talking on the phone, riding in the car, finishing a meal, drinking coffee, taking a break, or talking with friends.

Suggested strategies for the client:

- Change your routine when possible. Hold the phone receiver in the other hand, play with a straw when riding in the car, get up from table after a meal, doodle, play with a rubber band, or knit when taking a break, or eat hard candy when talking with friends.

- Distract yourself. Occupy your hands (knit or sew, play with a straw or rubber band, hold a pen or pencil, draw or doodle, squeeze a rubber ball, work on a craft project), your mouth (suck on hard candy, chew gum, use a toothpick or straw, sip water or juice, try a cinnamon stick, eat some fresh fruit), and your mind (think about the baby or a pleasant activity not involving smoking).
- Think your way out of the urge. Remind yourself why you decided to quit smoking. Tell yourself how well you have done so far not smoking, think about how proud you will feel getting through the day without a cigarette; or figure out how much money you are saving by not smoking.
- Change your environment. Remove things that might remind you to smoke, or go somewhere else in the house or outside when you get the urge to smoke.

Problem #4: Managing Withdrawal Symptoms

Some people have withdrawal symptoms for several weeks after quitting. Withdrawal symptoms are normal, although they may be uncomfortable. It is helpful to remember that they do not last long, and they are positive signs that your body is recovering from smoking.

Suggested strategies for the client:

- **Irritability.** Prepare people around you to expect that you may be irritable for several weeks. Decrease demands on yourself, drink lots of water or fruit juices to get the nicotine out of your system, avoid stimulants like caffeine in coffee and cola, take 10 slow, deep breaths to calm yourself down, do some physical activities.
- **Cough and sore throat.** Do not worry if your cough gets worse shortly after quitting. This is a good sign that your lungs are clearing. Take cough drops for temporary relief.
- **Dizziness and headache.** Your body is getting used to living without nicotine. Take a walk and breathe fresh air, sit down if you feel dizzy. Take a nap.
- **Hunger.** You may have an increased appetite; eat healthy low-fat snacks that are high in texture and crunch such as plain popcorn, pretzels, celery, carrots, and fruit. Suck on hard candy. Drink lots of water.
- **Difficulty concentrating.** Do something physical to burn off nervous energy (take a walk, clean the house, garden, dance). Reduce work demands during this period if possible. Work in short bursts rather than for extended periods, and get lots of sleep.
- **Constipation.** Increase the amount of fruit, vegetables, and bran in your diet, and drink lots of water.
- **Restlessness.** Do something physical (take a walk, clean the house, garden, or dance). Keep your hands busy (doodle, knit, play with a straw, rubber band, worry beads, a craft). Avoid caffeine.
- **Sleeplessness.** Avoid caffeine at night. Exercise more during the day. Go to bed only when tired. When you cannot sleep at night, get out of bed and do something such as reading or working on a hobby until drowsy.

Problem #5: Coping with Weight Gain

The average person gains no more than 10 pounds after quitting; and since weight gain during pregnancy is normal this is an ideal time to quit. Women tend to gain slightly more than men. More Information and guidance can be found in the 2008 US Public Health Service Treating Tobacco Use and Dependence Guideline: http://www.ahrq.gov/legacy/clinic/tobacco/tobaqrg.htm

Suggested strategies for the client:

- Recognize that weight gain is normal. Weight gain is far less harmful than the consequences of smoking. You are supposed to gain weight during pregnancy anyway, so this is a great time to quit smoking. Accept the weight gain and deal with it after you have your smoking under control after delivery.
- Increase your physical activity. This burns calories to help offset the decrease in metabolic rate associated with quitting smoking. You can do this by making some changes in your lifestyle. Walk instead of ride whenever possible. Take stairs instead of the elevator. Do something physical for recreation.
- Make some changes in your diet. Avoid foods high in fat (ice cream, cheese, whole milk, cream) and products made with butter, Crisco, coconut, palm, or hydrogenated oils. Avoid high fat snack foods such as chips, nuts, and chocolate. Substitute low-fat dairy product alternatives (skim milk, sherbet or ice milk, light cheeses). If you crave something sweet, eat something containing sugar but low in fat (hard candy, sherbet, fruit pops, graham crackers). For snacks, consider hard candy, ice chips, fruit pops, low fat yogurt, sherbet, plain popcorn, or pretzels.

Seek help from a Registered Dietician (RD) to help with meal planning. These services are covered under many health plans, Medicaid Maternity Support Services in Washington State, and the Supplemental Nutrition Program for Women, Infants, and Children.

Problem #6: Coping with "Slips"

Almost everyone slips up at some point during the quitting process. The trick is to learn from the slip and begin again.

Suggested strategies for the client:

- Do not tempt yourself by smoking even one drag off one cigarette; however, people sometimes slip and smoke a cigarette after quitting.
- Tell yourself that this relapse was a mistake, not a failure.
- Review your reasons for quitting. Blame the situation, not yourself. Renew your commitment to staying quit.
- Problem-solve how to avoid getting into that situation in the future.
- Review your commitment to quitting.
- Ask for help from others who want to see you succeed.

Provider Script for Managing Relapse

Acknowledge her smoking status and her feelings.

Provider prompt: "Okay, I understand that you're returned to smoking. How are you feeling?"

Ask her to describe the situation in which she relapsed.

Provider prompt: "Can you tell me what was going on when you had that first cigarette?" (Get a clear description of the situation or feeling.)

Use the problem-solving process to generate possible ways she could have handled that situation or feeling.

Provider prompt: "What are some other ways you could have handled that situation without smoking?" (Don't evaluate yet; add some suggestions from the problem solving section, page 11.)

Reassure her that people often quit a number of times before they're successful.

Provider prompt: "It's important for you to know that people often quit a number of times before they're successful."

Ask if she'd be willing to set a new Quit Day.

Provider prompt: "Would you be willing to set a new Quit Day?

Provider response if Yes: "That's great. What day would you like to set as your Quit Day? Do you have a sense of how you'll prepare for quitting?" (Review her plans, ask permission to give her materials and make arrangements to call her on her new Quit Day.)

Provider response if No: "Okay you aren't ready to set a quit day. What needs to happen for you to be ready to quit and be successful again?"

Postpartum Intervention

Relapse after birth is common. Approximately 60–80 percent return to smoking within one year after delivery. Women who have quit during pregnancy should be asked in the third trimester about their intention to resume smoking following birth and counseled. Postpartum visits should include the brief intervention and appropriate follow-up. Counseling should include information about secondhand smoke and its impact on infant heath.

Intention to Resume Smoking

Raise the issue of intention to resume smoking after pregnancy with woman, before delivery and in the postpartum period. A discussion provides another opportunity to recognize the woman's commitment and success with cessation during pregnancy. It also provides an opportunity to discuss any concerns or ambivalence she may have about being able to continue cessation, or her decision to return to cigarette use.

Provider script for discussing intention to resume smoking:

> *"You have maintained your commitment to protecting your health and health of your baby by not smoking during pregnancy. What are you thoughts about continuing this commitment after the baby is born?"*
>
> *"What do you think you need to help maintain your decision to stay tobacco free?"*

Secondhand Smoke[10]

Secondhand smoke is defined as both the smoke coming from the tip of a lit cigarette and the exhaled smoke from the smoker. Secondhand smoke exposure during pregnancy also increases the risk of low birth weight. Children exposed to secondhand smoke have higher rates of upper respiratory infections, colds, and asthma.

Tobacco smoke harms babies before and after they are born. Unborn babies are hurt when their mothers smoke or if others smoke around their mothers. Babies also may breathe secondhand smoke after they are born. Because their bodies are developing, poisons in smoke hurt babies even more than adults. Babies under a year old are in the most danger.

The sudden unexplained, unexpected death of an infant before age one is known as Sudden Infant Death Syndrome. The exact way these deaths happen is still not known. We suspect it may be caused by changes in the brain or lungs that affect how a baby breathes. During pregnancy, many of the compounds in secondhand smoke change the way a baby's brain develops. Mothers who smoke while pregnant are at greater risk to have their babies die of Sudden Infant Death Syndrome.

[10] US Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Secondhand Smoke, What It Means to You.* US Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

Babies who are around secondhand smoke, from their mother, father, or anyone else, after they are born, are also more likely to die of Sudden Infant Death Syndrome than children who are not around secondhand smoke.

For more information about secondhand smoke, go to Washington State Tobacco Prevention & Control website:

www.doh.wa.gov/YouandYourFamily/IllnessandDisease/TobaccoRelated
or www.smokefreewashington.com

Breastfeeding and Tobacco Use

According to the CDC, mothers who smoke are encouraged to quit; however, breast milk remains the recommended food for a baby even if the mother smokes. Although nicotine may be present in the milk of a mother who smokes, there are no reports of adverse effects on the infant due to breastfeeding. Secondary smoke is a separate concern regarding the child's long-term health. The American Academy of Pediatrics recognizes pregnancy and lactation as two ideal times to promote smoking cessation, but does not indicate that mothers who smoke should not breastfeed.

For more information, see CDC's Tobacco Information and Prevention Source (TIPS): www.cdc.gov/breastfeeding/disease/tobacco.htm

The La Leche League provides the following advice for breastfeeding women who continue to smoke:[11]

- Keep breastfeeding. Breastmilk is still the best food for your baby, even if you smoke.
- Avoid smoking while holding your baby.
- Smoke away from baby, preferably outdoors.
- Don't smoke in the car.
- Wear a smoking jacket. Remove it when you are done smoking and before holding your baby.
- Smoke right after nursing.
- Smoke as few cigarettes as possible.

[11] *Smoking and Breast Feeding – Tobacco Cessation Clinical Guide.* 2011. La Leche League.

Pharmacotherapy

The Department of Health does not recommend that all pregnant women who smoke use pharmaceutical cessation aids. However, heavy smokers who do not respond to a behavioral intervention may benefit from pharmacotherapy.[12] Prescribing any medication or encouraging the use of non-prescription medicines during pregnancy is a matter of individual clinical judgment. Risks and benefits must be evaluated and shared with the pregnant woman. Shorter courses at lower doses may be considered, if medications are recommended, although this needs to be balanced against potentially lowered effectiveness. The American College of Obstetricians and Gynecologists Smoking Cessation During Pregnancy Committee Opinion of November 2010 makes the following statements:

The US Preventive Services Task Force has concluded that the use of nicotine replacement products or other pharmaceuticals for smoking cessation aids during pregnancy and lactation have not been sufficiently evaluated to determine their efficacy or safety. Therefore, the use of nicotine replacement therapy should be undertaken with close supervision and after careful consideration and discussion with the patient of the known risks of continued smoking and the possible risks of nicotine replacement therapy. If nicotine replacement is used, it should be with the clear resolve of the patient to quit smoking. Recent research (Slokin and Gaysina, 2013) suggest that due to the adverse impact of nicotine on brain development, we should reconsider any use of NRT patches to achieve smoking cessation in pregnancy. This rate of administration delivers more nicotine to the fetus than does moderate smoking.[13]

Alternative smoking cessation agents used in the non-pregnant population include varenicline and bupropion. Varenicline is a drug that acts on brain nicotine receptors, but there is no knowledge as to the safety of varenicline use in pregnancy. Bupropion is an antidepressant with only limited data, but there is no known risk of fetal anomalies or adverse pregnancy effects. However, both these medications have recently added product warnings mandated by the US Food and Drug Administration about the risk of psychiatric symptoms and suicide associated with their use. Both bupropion and varenicline are transmitted to breast milk. There is insufficient evidence to evaluate the safety and efficacy of these treatments in pregnancy and lactation. Furthermore, in a population at risk for depression, medications that can cause an increased risk of psychiatric symptoms and suicide should be used with caution and considered in consultation with experienced prescribers only.[14]

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[12] Windsor R, Oncken C, Henningfield J, Hartman K, and Edwards N. "Behavioral and Pharmacological Treatment Methods for Pregnant Smokers: Issues for Clinical Practice." *Journal of the American Medical Women's Association*, 55(5), 304-310, Fall 2000.

[13] Gaysina D, Fergusson DM, Leve LD, Horwood J, Reiss D, Shaw DS, Elam KK, Natsuaki MN, Neiderhiser JM, Harold GT. (2013). Maternal Smoking During Pregnancy and Offspring Conduct Problems Evidence from 3 independent genetically sensitive research designs. *JAMA Psychiatry*, published online July 24, 2013.

[14] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." *ACOG Committee Opinion* 471. Washington, DC: ACOG, reaffirmed 2012.

The 2008 Public Health Service Clinical Practice Guideline "Treating Tobacco Use and Dependency" does not make a recommendation regarding medications use during pregnancy.[15]

E-cigarettes

The popularity of e-cigarettes continues to grow. Electronic cigarettes are intended for use by smokers of legal smoking age, and not by children or women who are pregnant or breast feeding. E-cigarettes are not intended to be used as a cessation aid as they may contain higher levels of nicotine than a standard cigarette.

Manufacturers of e-cigarettes claim the product is safer, more convenient, and more affordable than current tobacco products. However, the science behind these safety claims is limited. In fact, public health authorities generally agree on the need for more clinical studies on these products. At least one study has found that e-cigarette users inhale as much nicotine as smokers of traditional cigarettes.[16]

The Food and Drug Administration (FDA), the federal agency responsible for regulating tobacco products, reported its laboratory analysis of e-cigarettes indicated carcinogens (cancer-causing agents) and toxic chemicals such as diethylene glycol (ingredient found in antifreeze).[17] Also, the second hand vapor from electronic devices needs additional clinical studies.

Until additional studies are complete, pregnant and nursing moms should not be using e-cigarettes. Patients using these devises should be referred for tobacco counseling.

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[15] US DHHS Public Health Service. *Clinical Practice Guideline: Treating Tobacco Use and Dependence*, May 2008.

[16] Etter, J.F., and Bullen, C. (2011). Saliva cotinine levels in users of electronic cigarettes. *European Respiratory Journal*. 38: 1219-1220.

[17] U.S. Food and Drug Administration. (2009). Summary of Results: Laboratory Analysis of Electronic Cigarettes Conducted By FDA. Available at: www.fda.gov/NewsEvents/PublicHealthFocus/ucm173146.htm

Pharmacotherapy Reference Guide (see PDR/Package Insert for FDA Approved Product Information*)

Product	Examples	OTC?	Dose Absorbed	Usual Product Dosing *Consult the PDR or package insert for updated and full dosing instructions. Dosing may require adjustment based on experience and concurrent medications and conditions.	Potential Contraindications *Partial list only. Please consult a Package Insert for an updated/completed list.
Patch (Band-Aid like)	**Nicotine Transdermal System Step 1** (Various, e.g., Harbitrol®, Nicoderm CQ®, and generic)	Yes	21[a]	>10 cigarettes per day Weeks 1–6: Use one 21mg patch/day Weeks 7–8: Use one 14mg patch/day Weeks 9–10 : Use one 7mg patch/day	• Under 18 years of age • Pregnant or breastfeeding (Pregnancy Category D)[b] • Have heart disease, recent MI, or irregular heartbeat • Rx meds for depression or asthma may need adjustment. • Allergic to adhesive tape or have skin problems • Potential adverse impact on fetal brain development[c]
	Nicotine Transdermal System Step 2 (Various, e.g., Harbitrol®, Nicoderm CQ®, and generic)	Yes	14[a]	≤10 cigarettes per day. Do NOT use Step 1 products. Weeks 1–6 : Use one 14mg patch/day Weeks 7–8: Use one 7mg patch/day	
	Nicotine Transdermal System Step 2 (Various, e.g., Harbitrol®, Nicoderm CQ®, and generic)	Yes	7[a]		

* The information on this chart has not been adjusted for pregnant women.

a The amount of nicotine absorbed in 24 hours (mg/day).

b FDA Pregnancy Category D: "Positive evidence of risk. Investigational or postmarketing data show risk to the fetus. Nevertheless, potential benefits may outweigh the potential risks. If needed in a life-threatening situation or a serious disease, the drug may be acceptable if safer drugs cannot be used or are ineffective."

c Transdermal patches deliver more nicotine to the fetus than does moderate smoking.

Produced by the Tobacco Cessation Resource Center (TCRC).
This document is intended for general reference only and should not be used for prescribing purposes.

Pharmacotherapy Reference Guide (see PDR/Package Insert for FDA Approved Product Information*)

Product	Examples	OTC?	Usual Product Dosing *Consult the PDR or package insert for updated and full dosing instructions. Dosing may require adjustment based on experience and concurrent medications and conditions.	Potential Contraindications *Partial list only. Please consult a Package Insert for an updated/ completed list.	Usual Product Dosing *Consult the PDR or package insert for updated and full dosing instructions. Dosing may require adjustment based on experience and concurrent medications and conditions.	Suggested Use Instructions *See PDR or Package Insert for full use instructions.	Cost
Gum brands (stiff, gum-like consistency)	Nicorette® NICOrelief® Thrive® Generics (2 or 4 mg.) *Comes in regular, mint, and other flavors*	Yes	• <25 cigarettes per day = 2mg dose to start • ≥25 cigarettes per day = 4mg dose to start Weeks 1–6: 1 piece every 1–2 hours Weeks 7–9: 1 piece every 2–4 hours Weeks 10–12: 1 piece every 4–8 hours *Note: See instructions and additional resources for how to use.*	• Under 18 years of age • Pregnant or breastfeeding (Pregnancy Category C)** • Have heart disease, recent MI, or irregular heartbeat • Rx meds for depression or asthma may need adjustment. • Stomach ulcer • Dental problems or jaw disorder • Take insulin for diabetes	• <25 cigarettes per day = 2mg dose • ≥25 cigarettes per day = 4mg dose Weeks 1–6: 1 piece every 1–2 hours Weeks 7–9: 1 piece every 2–4 hours Weeks 10–12: 1 piece every 4–8 hours *Note: See instructions for how to use.*	• Not to be chewed as if regular gum. • Chew 5 or 10 times until tingles, then park between cheek and gum. When tingle is gone, chew again until tingle returns. Repeat until gum fails to produce tingle. • Discard after 20–30 minutes. • Avoid acidic beverages during use and 15 minutes before use. • Do not smoke or use tobacco while using gum.	About 35–60¢ per piece. Minimum initial daily cost of $4–6 (actual costs depend on how many pieces are used per day)

* The dosage on this chart has not been adjusted for pregnant women.

** FDA Pregnancy Category C: "Risk cannot be ruled out. Human studies are lacking, and animal studies are either positive for fetal risk or lacking. However, potential benefits may justify the potential risks."

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Pharmacotherapy Reference Guide (see PDR/Package Insert for FDA Approved Product Information*)

Product	Example Brands/ Strengths	OTC?	Product Dosing *Consult the PDR or package insert for updated and full dosing instructions. Dosing may require adjustment based on experience, concurrent needs, and conditions.	Potential Contraindications *Partial list only. Please consult a Package Insert for an updated/ completed list.	Suggested Use Instructions *See PDR or Package Insert for full use instructions.	Cost *May vary with health plan and/or purchasing location
Lozenge (similar to a throat lozenge)	Commit™ Nicorette® *Comes in regular, mint, and cherry* Nicorette® Mini lozenge**	Yes	• 2mg dose – for patients who smoke first cigarette >30 minutes after waking up • 4mg dose – for patients who smoke first cigarette <30 minutes after waking up • Use up to 20 lozenges/day; use up to 12 weeks Weeks 1–6: 1 lozenge every 1–2 hours Weeks 7–9: 1 lozenge every 2–4 hours Weeks 10–12: 1 lozenge every 4–8 hours *Do not use more than 5 lozenges in 6 hours or more than 20/day.*	• Under 18 years of age • Pregnant or breastfeeding (Pregnancy Category C) • Have heart disease, recent MI, or irregular heartbeat • Rx meds for depression or asthma may need adjustment. • Stomach ulcer • Dental problems or jaw disorder • Diabetes	• Slowly dissolve in mouth. • Do not chew or swallow. • Do not use more than one lozenge at a time. • Do not eat or drink while lozenge is in mouth. • Wait 15 minutes after eating or drinking. • Discontinue use after 12 weeks. • Do not smoke or use tobacco while using lozenge.	About $3–12 per day (depending on how many lozenges are used per day)

* The dosage on this chart has not been adjusted for pregnant women.
** Dissolves faster than regular lozenges.

Produced by the Tobacco Cessation Resource Center (TCRC).
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Pharmacotherapy Reference Guide (see PDR/Package Insert for FDA Approved Product Information*)

Product	Example Brands/ Strengths	OTC?	Product Dosing *Consult the PDR or package insert for updated and full dosing instructions. Dosing may require adjustment based on experience, concurrent needs, and conditions.	Potential Contraindications *Partial list only. Please consult a Package Insert for an updated/ completed list.	Suggested Use Instructions *See PDR or Package Insert for full use instructions.	Cost *May vary with health plan and/or purchasing location
Inhaler (cigarette-like device with a mouthpiece and cartridge)	Nicotrol®	Rx only	• Initial treatment: Up to 12 weeks of 6–16 cartridges/day followed by • Gradual reduction (if needed): 6–12 weeks • Not for use beyond 6 months	• Heart problems (heart attack, irregular heartbeat, severe or worsening heart pain) • Stomach ulcers • Overactive thyroid • High blood pressure • Allergies to menthol or drugs • Diabetes • Kidney or liver disease • Wheezing or asthma • Pregnancy Category D	• Insert cartridge into holder, following package instructions. • Puff, as with a cigarette, but do not inhale into lungs. (Vapor is absorbed through mouth and throat tissues.) • Do not smoke or use tobacco while using inhaler.	$10–17 per day (depending on how many cartridges are used per day). Coupons and incentive programs may be available to reduce cost.
Nasal Spray (delivered similar to a decongestant)	Nicotrol NS®	Rx only	• 1 dose = 1mg nicotine (2 sprays, one in each nostril) • 1 or 2 doses per hour, which may be increased up to a maximum recommended dose of 40mg (80 sprays) per day *For best results, patients should be encouraged to use at least the recommended minimum of 8 doses per day, as less is unlikely to be effective.*	• Chronic nasal problems, such as nasal allergies, inflammation, nasal polyps (growths), and sinusitis • Heart problems (heart attack, irregular heartbeat, severe or worsening heart pain) • Stomach ulcers • Overactive thyroid • High blood pressure • Allergies to drugs • Diabetes • Kidney or liver disease • Wheezing or asthma • Pregnancy Category D	• Sprayer may require priming before use. • Blow nose before use. • Insert tip of nozzle well into nostril. • Tilt head back slightly. • Breath through mouth. • Press quickly to deliver spray. • Repeat procedure with other nostril. • Do not inhale or sniff through the nose or swallow when administering. • Do not blow nose for 2–3 minutes after use. • Do not smoke or use tobacco while using nasal spray.	About $75 per 10ml bottle, which contains about 200 sprays (or 100 dosages of 1mg each). Coupons and incentive programs may be available to reduce cost.

* The dosage on this chart has not been adjusted for pregnant women.

Produced by the Tobacco Cessation Resource Center (TCRC).
This document is intended for general reference only and should not be used for prescribing purposes.

Appendix A – Health Care Authority Medical Program Smoking Cessation Benefit

This benefit covers all clients 18 years and older and all pregnant women regardless of age who are enrolled in a Health Care Authority Medicaid program. Everyone must go through the quitline. You do not need to note that the client is pregnant. Reimbursement is provided for smoking cessation referral, if the smoking referral is the sole purpose of the entire visit. Bupropion prescriptions will be covered. Estimated delivery date is no longer required on initial requests for buprupion but may be requested if women need an extension.

Health Care Authority Medical Program Smoking Cessation Benefit

The medical programs' coverage is expanded and includes a smoking cessation benefit for clients. The benefit, which can include free counseling and prescription drugs, represents a major advancement in public health of our state. Below is a brief overview of how the benefit works and the services available for clients.

Implementation date:

July 1, 2008

Client/Provider access:

Call/refer to the toll-free Washington State Tobacco quitline:

English: 1-800-QUIT-NOW or 1-800-784-8669
Spanish: 1-855-DEJELO-YA or 1-855-335-3569
TTY Line and video relay: 1-877-777-6534 (for hearing impaired)

Asian Smokers Quitline
Chinese (Cantonese and Mandarin): 1-800-838-8917
Korean: 1-800-556-5564
Vietnamese: 1-800-778-8440

Fax Referral: 1-800-483-3078
Web: www.quitline.com
www.smokefreewashington.com

Free services available for clients:

- Phone counseling and follow-up support calls through the quitline
- Nicotine patches or gum through the quitline, if appropriate
- Prescription medications recommended by the quitline and prescribed by individual physicians, if appropriate

Provider guidelines:

- Refer all clients to the Tobacco quitline at 1-800-QUIT-NOW
- Review the Health Care Authority-approved smoking cessation program provider recommendations for writing a smoking cessation prescription
- Complete the Health Care Authority-approved smoking cessation program contraindication evaluation tool for each client
- Review medication recommendation from the quitline and write prescription, if appropriate

Medicaid will reimburse physicians for the following services:

- Smoking cessation referral visits. (Physicians can be reimbursed for **both** prenatal visit and smoking cessation.)
- Review of prescription medication recommendation, write and fax prescription, if appropriate

Client eligibility:

All clients age 18 years and older and all pregnant women regardless of age who are enrolled in a Health Care Authority Medicaid program are eligible for smoking cessation services through the tobacco quitline.

Clients enrolled in the Family Planning Only, Acute and Emergent, and Take Charge programs are not eligible for prescription drugs and smoking cessation services provided by the primary care provider. These clients are eligible for services from the tobacco quitline.

Additional information:

For more information about the Medicaid cessation benefit, call the Health Care Authority at 1-800-562-3022
http://www.hca.wa.gov/medicaid/news/documents/fact_smoking.pdf

HCA Medicaid Medical Provider Guide
http://www.hca.wa.gov/medicaid/billing/documents/physicianguides/physician-related_services_mpg.pdf

For more information about the tobacco quitline, visit www.quitline.com/ (tobacco user information)

To order brochures and business cards, go to PCHClearinghouse@doh.wa.gov

Appendix B – Washington State Tobacco Quitline (as of August 2013)

For current quitline information, visit:
www.quitline.com

Washington State Tobacco Quitline coverage matrix:
www.doh.wa.gov/Portals/1/Documents/Pubs/340-207-TobaccoQuitLineCoverage.pdf

Residents should call the tobacco quitline to determine eligibility:
English: 1-800-QUIT-NOW (1-800-784-8669)
Spanish: 1-855-DEJELO-YA (1-855-335-3569)
All callers will get at least one call and self-help materials.

Quitline Coverage for Pregnant Women

- Pregnant women on Medicaid and Medicaid Management Care Plans qualify for up to 10 calls:
  - First 7 calls will be completed within 60–90 days of enrollment.
  - One call 30 days prior to planned due date.
  - Two postpartum contacts at 15 and 45 days postpartum (for women who quit).
- Pregnant women covered by private insurance that includes quitline services also qualify.
- All other pregnant women will qualify for one call only.

Quitline Pregnancy Program Overview: 10-Call Intensive

The Washington State quitline offers a cost-effective, evidenced–based tobacco cessation treatment program for pregnant smokers. This program offers pregnant smokers greater intensity of behavioral support – 10 calls. The treatment plan is tailored to meet their needs and, for those who quit, offers additional postpartum contact to prevent relapse.

Quitting smoking is one of the most important steps a pregnant woman can take. Smoking continues to be a leading cause of poor pregnancy outcomes. The health risks to the fetus alone are significant. Pregnant smokers who quit have a significant chance of relapse during the postpartum period. Our pregnancy program addresses all these topics by using evidenced-based treatment practices to help pregnant smokers quit and remain tobacco free.

Specially trained groups of Pregnancy Quit Coaches use protocols developed specifically for this program to:

1. Address the health risks of continued smoking to the mother and fetus, and emphasize the health benefits of quitting for both.
2. Take a women-centered approach, balancing the benefits of quitting for both the fetus and the woman. The quit coach will provide tobacco dependence treatment for the woman separate from being an expectant mother.

3. Emphasize the importance of remaining tobacco free after delivery of her child. Protocols designed to emphasize the importance of remaining tobacco free beyond delivery will be incorporated into the program, with at least two postpartum interventions. Exposure to second-hand smoke is a major health risk to the baby (asthma, ear infections, SIDS, etc.) and sustaining cessation beyond delivery is equally important to the health of the mother. To this end, motivational messages and protocols to problem solve barriers to sustaining abstinence will be incorporated into the intervention content.
4. Quit coaches provide information about pharmacotherapy options to pregnant women. The intervention will seek to educate women interested in using a cessation medication to engage in a meaningful discussion with their physician about the pros and cons of using pharmacotherapy to aid their cessation efforts.
5. For women unwilling or unable to quit entirely, the quit coach will validate efforts to cut down on the number of cigarettes smoked per day, while continuing to emphasize complete abstinence as the ultimate goal.
6. Assess whether the caller has a partner. Assess partner smoking status and whether the partner is supportive of the pregnancy and her quitting smoking.
7. Quit kit materials designed to meet the needs of pregnant smokers are incorporated into the program design. These materials (*Need Help Putting Out That Cigarette?*) will meet the literacy needs of the target population and are currently being provided to pregnant women. These materials are available in English and Spanish.
8. Program will include:
    - Up to 10 calls with relapse prevention sensitivity. The first 7 calls will be completed within 60–90 days of enrollment.
    - One call will be delivered 30 days prior to the planned due date.
    - Will include two postpartum contacts (15 days and 45 days postpartum) for those women who quit.
    - Structured content for pregnant smokers not ready to quit.

Washington State Tobacco Quitline

Current Coverage

Healthy Communities Washington
Healthy people in healthy places

1-800-QUIT-NOW or 1-800-784-8669*
1-855-DEJELO-YA or 1-855-335-3569*
***toll free number**

If you are …	What to expect when calling the quitline	Resources Available	Additional Information
Uninsured	***One-Call Program*** • You can call the quitline directly for counseling anytime. • You will receive one call with a quit coach.	• Self-help materials	• You must have quit or be prepared to quit within 30 days. • You must be age 18 or over to receive materials or calls back from a quit coach. • Enrollment is limited to once per year.
Underinsured (have insurance, but no benefit for cessation)	***One-Call Program*** • You can call the quitline directly for counseling anytime. • You will receive one call with a quit coach.	• Self-help materials	• These services are offered regardless of your insurance status. • You must be age 18 or over to receive materials or calls back from a quit coach. • Enrollment is limited to once per year.
Under the age of 18	***One-Call Program*** • You can call the quitline directly for counseling anytime.	• Due to Washington State privacy laws, we are not able to mail materials to you if you are under the age of 18	
Pregnant	***One-Call Program*** • You can call the quitline directly for counseling anytime.	• Self-help materials	• These services are offered regardless of your insurance status. • Enrollment is limited to once per year. • You must be age 18 or over to receive materials or calls back from a quit coach.
Pregnant and have Washington State Medicaid Fee for Service (FFS) or Medicaid Managed Care	***Multiple-Call Program*** • You can call the quitline directly for counseling anytime. • You will receive nine follow-up calls from your quit coach.	• Self-help materials • 12 weeks of Buproprion free (with a prescription from your provider and if indicated as medically appropriate)	• You must be age 18 or over to receive materials or calls back from a quit coach. • Call the quitline to see what your plan covers. Have your insurance identification card with you when you call.

If you have …	What to expect when calling the quitline	Resources Available	Additional Information
Washington State Medicaid Fee For Service (FFS)	***Multiple-Call Program*** • You can call the quitline directly for counseling anytime. • You will receive four follow-up calls from your quit coach.	• Self-help materials • Up to 12 weeks of nicotine gum or patches free if appropriate OR up to 12 weeks of Buproprion or Varenicline (with a prescription from your provider and if indicated as medically appropriate)	• Coverage will vary based on your Medicaid FFS benefits. Have your insurance identification card with you when you call. • WA State Medicaid FFS requires enrollment in phone coaching to receive medications. • You must be age 18 or over to receive materials or calls back from a quit coach. • To receive medications, you must quit or be prepared to quit within 30 days.
Washington State Medicaid Managed Care	***Multiple-Call Program*** • You can call the quitline directly for counseling anytime. • You will receive four follow-up calls from your quit coach.	• Self-help materials • Nicotine gum, patches, or prescriptions for Buproprion/Varenicline may or may not be covered. Check your Managed Care Plan benefits	• Call the quitline to see what your plan covers. Have your insurance identification card with you when you call. • Benefits vary among Medicaid Managed Care plans (Amerigroup, Community Health Plan of WA, Coordinated Care Corporation, Molina Healthcare of WA and United HealthCare Community Plan). • You must be age 18 or over to receive materials or calls back from a quit coach. • To receive medications, you must have quit or be prepared to quit within 30 days.
Indian Health Services or the Veterans Health Administration	***One-Call Program*** • With a referral - You can call the quitline directly for counseling anytime. • You will receive one call with a quit coach.	• Self-help materials	• You must have quit or be prepared to quit within 30 days. • You must be age 18 or over to receive materials or calls back from a quit coach.
Private Insurance	***One-Call Program*** • The quitline covers 25 private insurance companies. Check your insurance benefits guide to see if you are covered for telephone counseling to quit tobacco.	• Varies with each plan	• Coverage will vary depending on your plan. The quitline has 25 private employee insurance plans that offer services in Washington. • Have your insurance identification card with you when you call.

Last Updated 8/20/13

Washington State Department of Health

DOH 340-207 August 2013

For persons with disabilities, this document is available on request in other formats.
To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

Appendix C – Quitline Fax Referral

As a health care provider, you play an important role in helping your smoking patients quit tobacco use. Did you know that when you refer your patient to a quitline, they are twice as likely to quit? As a health care professional, you can even double this percent by using a Fax referral to the quitline.

The Fax Referral Program connects users to the Washington State Tobacco Quitline through you, the health care provider. The quitline offers free evidence-based telephone counseling, materials, and medication (when appropriate) to eligible Washington residents who are interested in quitting tobacco.

Through the Fax Referral Program, the quitline initiates the first contact with the potential participant, which can greatly increase the chances of successful follow-up, especially for those who might be hesitant to begin treatment on their own.

More information about the Fax Referral Program and tools can be found at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/ProfessionalResources/TobaccoCessationResources.aspx

Washington State Tobacco Quitline

Frequently Asked Questions for a Fax Referral

Healthy Communities Washington
Healthy people in healthy places

Fax Referral

Q: ***How does the fax referral program work?***
A: The Health Care Provider and patient/tobacco user determine that the Quitline is a good referral resource. The tobacco user completes a fax referral form with the Health Care Provider or another clinic/office member. A signed form by the tobacco user with a current or valid phone is required for processing. The clinic faxes the form to the Quitline. To receive an outcome of the interaction, clinics must include their fax number on the form. The Quitline makes three attempts to reach the tobacco user (traditionally, the tobacco initiates the call to the Quitline – the fax referral allows the Quitline to reach out directly to the tobacco user). After three attempts, the Quitline faxes the clinic an outcome report (to be filed in the patient's chart at your clinic), detailing the outcome of the outreach.

Q: How soon after the form is faxed do patients receive a call from the Quitline?
A: Participants (your patients or clients) receive a call from the Quitline within 48 hours from the time you send your fax. The fax must have an updated phone number where the Quitline can reach the participant.

Q: How many times per year can I fax in a fax referral form for a patient?
A: Quitline enrollments are limited to one per year. However, if the participant declines services when reached by the Quitline, the services will still be available to that participant at another time. You can discuss the Quitline with the participant at another visit and re-submit another fax referral or encourage the participant to call on his/her own, if appropriate.

Q: How do I know if my patient accepted service from the Quitline?
A: The Quitline will send a Fax Back Outcome Report to your clinic/organization after three attempts have been made to reach the participant, or after connecting with the participant.

Q: What do the outcomes listed on my Fax Back Outcome Report mean?
A: There are three possible outcomes. They are listed below:

Accepted: The patient/participant accepts and enrolls in an eligible Quitline program.
Declined: The patient/participant declines to enroll in an eligible Quitline program.
Unreachable: The patient/participant is unreachable after three attempts.

Q: How do I know what kind of service the Quitline will provide my patient?
A: Details about the service, if accepted, are listed on the Fax Back Outcome Report that is sent your clinic/organization by the quitline. For more information about the services your patients are eligible to receive through the Quitline, see the Quitline Coverage Sheet.

Q: If a patient refuses the Quitline services when called, can they still call on their own to begin services with the Quitline at another time?
A: Yes, if a patient refuses Quitline services when called through the fax referral program, he or she can still initiate a call into the Quitline at any time to receive service.

Q: Why should I use a Fax Referral instead of just telling my patient to call the Quitline?
A: The Fax Referral eliminates the barrier of the tobacco user having to initiate the first call to the Quitline. It allows the provider / clinic to ensure a proactive follow-up step after the visit. It creates an easy opportunity for the provider to take action with the tobacco user at the time of the visit. The program notifies providers of any Quitline follow-up that occurs outside of the clinic/organization through a Fax Back Report, detailing the services the tobacco user will receive. Finally, it allows for follow-up in clinics or areas where follow-up might not otherwise be possible (e.g., ER/ED).

Q: Are pregnant women in the contemplation stage of quitting eligible to fill out the fax referral form and receive a call from the quitline?
A: Yes, pregnant women who are contemplating quitting tobacco can fill out the fax referral form with their provider and receive a call back from the quitline. The quit coaches at the quitline are equipped to support pregnant women in the contemplation stage of change as well as those who are ready to quit.

Please note, there is a line on the fax referral form that asks patients to initial the statement, "I am ready to quit using tobacco…" This line does not need to be initialed by pregnant women in the contemplation stage.

Q: Are Washington State residents under the age of 18 eligible to fill out the fax referral?
A: No. Residents under the age of 18 are only eligible to receive services by calling the Quitline directly due to Washington State youth emancipation laws and regulations.

Q: Where do I find the FAX referral form and phone number?
A: The FAX referral form is located at www.quitline.com. You can FAX the official form to the Quitline by dialing 1-800-483-3078.

For more information about the Washington State Tobacco Quitline or the Fax Referral Program, please contact us at: mailto:PCHClearinghouse@doh.wa.gov

Washington State Department of Health
DOH 340-222

Washington State Department of Health

DOH 340-221 May 2013

WASHINGTON STATE TOBACCO QUIT LINE
FAX REFERRAL FORM Fax Number: 1-800-483-3078

Provider Information: **Date: ___/___/____**

Health Care Provider Name: _____

Clinic Name: _____

Clinic Address: _____ **City:** _____ **Zip:** _____

Contact Name (nurse, med. asst., etc.): _____

Fax: (____) _____ - _____ **Phone** (____) _____- _____ **Email:** _____

I am a HIPAA – Covered Entity (Please check one) _____ Yes _____ No _____ I Don't Know

---

Patient Information: **Gender: Male _____Female_____** **Pregnant? Y __ N __**

Patient Name: _____ **DOB: ____/___/____**

Address: _____ **City:** _____ **Zip:** _____

Home #: (_____) _____ - _____ **Wk #:** (_____) _____-_____ **Cell #:** (_____) _____ - _____

The Washington Tobacco Quit Line will call you. Please check the best times for them to reach you. The Quit Line is open 7 days a week:

‰ **5am-8am** ‰ **8am–11am** ‰ **11am-2pm** ‰ **2pm-5pm** ‰ **5pm-8pm** ‰ **8pm-12am**

Within this time frame, please contact me at (check one):_____hm/__wk/__cell

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_____ I am ready to quit tobacco and request the **Washington Tobacco Quit Line** contact me to help
(Initial) me with my quit plans.

_____ I agree to have the **Washington Tobacco Quit Line** tell my health care provider(s) that I
(Initial) enrolled in Quit Line services and provide them with the results of my participation.

_____ Interpretation performed
(Initial)

Congratulations on taking this important step! Telephone support from a Quit Coach will greatly increase your chance of success.

Patient Signature: _____ **Date: _____/____/____**

Appendix D – The 5 Rs

Enhancing motivation to quit tobacco

Motivational interventions are most likely to be successful when the clinician is empathic, promotes patient autonomy, avoids arguments, and helps identify the client's previous successful behavior changes. The 5 Rs provide motivational intervention that provides the clinician an opportunity to educate, reassure, and motivate.

Relevance

Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (for example, having children in the home), health concerns, age, gender, and other important characteristics (for example, prior quitting experience, personal barriers to cessation).

Risks

The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (for example, smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of risks are:

- **Acute risks:** Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, increased serum carbon monoxide.
- **Long-term risks:** Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (bronchitis and emphysema), long-term disability and need for extended care
- **Environmental risks:** Increased risk of lung cancer and heart disease in spouses; higher rates of smoking by children of tobacco users; increased risk for low birth weight, Sudden Infant Death Syndrome, asthma, middle ear disease, and respiratory infections in children of smokers.

Rewards

The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of rewards follow:

- Improved health
- Food will taste better
- Improved sense of smell
- Save money
- Feel better about yourself
- Home, car, clothing, breath will smell better
- Can stop worrying about quitting
- Set a good example for children
- Have healthier babies and children

- Not worry about exposing others to smoke
- Feel better physically
- Perform better in physical activities
- Reduced wrinkling/aging of skin

Roadblocks

The clinician should ask the patient to identify barriers or impediments to quitting and not elements of treatment (problem-solving, pharmacotherapy) that could address barriers. Typical barriers might include:

- Withdrawal symptoms
- Fear of failure
- Weight gain
- Lack of support
- Depression
- Enjoyment of tobacco

Repetition

The motivational intervention should be repeated every time an unmotivated patient visits the clinic.

Material in Appendix D reprinted from US DHHS Public Health Service. *Clinical Practice Guideline: Treating Tobacco Use and Dependence,* May 2008.

Appendix E – Stages of Change and Motivational Interviewing

Examples of scenarios you may encounter when discussing smoking cessation (based on the Stages of Change and Motivational Interviewing).

The Stages of Change

The Stages of Change model developed by Prochaska and DiClemente (1982) is one approach to understanding the steps to changing tobacco use during pregnancy. The stages of change are:

- Pre-contemplation (not ready to quit)
- Contemplation (thinking about quitting)
- Preparation (ready to quit)
- Action (quitting)
- Maintenance (staying quit)
- Relapse (using again)

Precontemplation

The woman is not considering change during the pre-contemplation stage.

- She may not believe it necessary (for example: she smoked during her last pregnancy and nothing happened, or her mother smoked while pregnant with her and she is okay).
- She may not know or understand the risks involved.
- She may have tried many times to quit without success, so she has given up and does not want to try again.
- She may have gone through withdrawal before and is fearful of the process or its effects on her body.
- She may feel strongly that no one is going to tell her what to do with her body.
- She may have family members or a partner, whom she depends on, who smoke. She may not contemplate changing when everyone else in her environment continues to smoke.
- She may have multiple stressors in her life and tobacco use is her way of coping.

The woman in pre-contemplation may be resistant, reluctant, or resigned.

Resistant: "Don't tell me what to do."

Provider response: Work with the resistance. Avoid confrontation by giving facts about what smoking does to her and her fetus. Ask what she knows about the effects of tobacco. Ask permission to share what you know, then ask her opinion of the information. This often leads to a reduced level of resistance and allows for a more open dialogue.

Reluctant: "I don't want to change. There are reasons. How will I cope?"

Provider response: Empathize with her perceived barriers to change. It is possible to give strong advice and still be empathetic to possible hardships that come with changing. Guide her problem solving. (See page 11)

Resigned: "I can't change, I've tried."

Provider response: Instill hope. Explore barriers to change. (See page 11)

These clients may respond to a brief motivational intervention called the "5 Rs." (See Appendix D)

Contemplation

The woman is ambivalent about changing her behavior. She can think of the positive reasons to change but also is very aware of the negative sides of change.

Ambivalent: "I know I should quit. I feel guilty every time I have to light up."

Provider response: Health care providers can share information on the health benefits of smoking cessation for the woman and her fetus. The woman in contemplation will hear these benefits, but is very aware of the negative aspects of change on her life. Help the woman explore goals for a healthy pregnancy, and how to deal with the negative aspects of abstinence. (See pages 11–14) Reinforce that she can quit smoking.

Preparation

The woman's ambivalence is shifting toward changing her behavior. She is exploring options to assist her process. She may be experimenting by cutting down, or has been able to quit for one or more days. Although her ambivalence is lessening, it is still present and may increase when she is challenged by those around her, or triggered by stress or the environment.

Preparing: "Sometimes I can skip my lunch break cigarette and I feel good about that, but I can't seem to skip the afternoon cigarette break. All my friends are smoking out there without me."

Provider response: Acknowledge her strengths. Anticipate problems and pitfalls to changing, and assist the woman in generating her own quit plan. Help her problem solve her barriers to success. (See page 11)

Action

The woman has stopped smoking.

Abstainer: "It's tough, but I know this is important for my baby's health. I'm glad I quit."

Provider response: Acknowledge her success and how she is helping her infant and herself. Ask her to share how she has succeeded and how she is coping with the challenges of not smoking. Offer to be available for assistance if she feels that she wants to smoke again. Provide relapse prevention materials.

Maintenance

The woman stopped smoking before she became pregnant or early in her pregnancy and has maintained abstinence for several months. However, she may consider this cessation as only an interruption in her smoking behavior.

Maintainer: "I'll stop while I'm pregnant" or "If I can stop now, I can stop whenever I want."

Provider response: Check in with the woman on a regular basis. Affirm her success at cessation and assess how she is handling triggers and stress. Pregnancy offers a unique incentive to quit and once she is not pregnant, she may easily smoke again. Encourage her to stay quit for her own health and the health of her child. Taking time to explore this with the client before she delivers may help reduce her chance of relapse.

Relapse

The woman returns to smoking. The incidence of relapse for heavy smokers and for postpartum women who are able to quit during pregnancy is high. After the baby is born, the majority of women return to smoking.

Relapser: "I tried, but I couldn't maintain. At least I quit while I was pregnant."

Provider response: For women who have quit during pregnancy, anticipatory guidance may be helpful in preventing relapse after delivery. Identify strategies for dealing with triggers and stressors that may present after delivery. If relapse is evident at future visits, help the woman identify what steps she used in previous attempts to quit. Offer hope and encouragement, but allow the woman to explore the negative side of quitting and what she can do to deal with those issues. How did she deal with those issues in the past? Explore what worked and didn't work for her. Offer resources to help her return to abstinence. (See page 15)

Appendix F – Tobacco Cessation Resources

Health Care Authority Medicaid Program Smoking Cessation Benefit

Benefit includes the following: phone counseling and follow-up calls (through the State quitline), nicotine patches or gum, and prescription medications recommended by a quitline counselor and prescribed by individual physicians, if appropriate.

For more information:
http://www.hca.wa.gov/medicaid/news/documents/fact_smoking.pdf

Washington Tobacco Quitline

The quitline provides tobacco cessation materials and telephone consultation with quitline specialists. Pregnant women can also receive free intensive telephone counseling services that will provide up to 10 calls and pregnancy specific materials.

1-800-QUIT-NOW (1-800-784-8669)
Monday through Sunday, 5:00 a.m. – 9:00 p.m.

Patient Education Resources

The National Partnership to Help Pregnant Smokers Quit
Need Help Putting Out That Cigarette – Plan to Quit
Online information and booklet: www.helppregnantsmokersquit.org/quit/plan.html

A Pregnant Woman's Guide to Quit Smoking is a 40-page easy-to-follow booklet written at the 6th-grade reading level. The booklet assists pregnant women to develop and implement a quit plan. It has been designed and tested with over 6,000 pregnant smokers and outlines a self-evaluation process to help build smoking cessation success over a 10-day period. This booklet costs between $3.25 and $6.00, depending on number of copies ordered. Contact Society for Public Health Education at 202-408-9804 or info@sophe.org.

For Health Care Providers

Toolkit and CME

Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Women Quit Smoking. 2011 Self-Instructional Guide and Toolkit. CME available upon completion.
http://www.acog.org/~/media/Departments/Tobacco%20Alcohol%20and%20Substance%20Abuse/SCDP.pdf?dmc=1&ts=20131001T1239343905

ACOG Smoking Cessation eToolkit

http://www.acog.org/About_ACOG/ACOG_Districts/District_II/Smoking_Cessation_eToolkit

Quitline Resources

Tobacco Cessation Resources for Healthcare Providers Webpage:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/ProfessionalResources/TobaccoCessationResources.aspx

You will find:

- Quitline Coverage
- *Frequently Ask Questions for Health Providers*
- *Washington State Tobacco Quitline Fax Referral Form*
- Blank FAX Referral Form

Easy Ways to Talk to Your Patients About Quitting

What to Tell Your Patients About Smoking (PDF, CDC):
http://www.cdc.gov/tobacco/data_statistics/sgr/2010/clinician_sheet/pdfs/clinician.pdf

The Brief Tobacco Intervention: The 2As & R, The 5As – Pocket Card (PDF, CDC):
http://www.cdc.gov/tobacco/campaign/tips/groups/hcp/twyd-5a-2a-tobacco-intervention-pocket-card.pdf

A Brief Intervention to Help Patients Quit Smoking – Video, Dr. Timothy McAfee, (CDC):
http://www.cdc.gov/tobacco/campaign/tips/groups/health-care-providers.html
(To view the video, scroll down to Easy Ways to Talk to Your Patients About Quitting.)

Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians (PDF, U.S. Department of Health and Human Services, 1MB):
http://www.ahrq.gov/legacy/clinic/tobacco/tobaqrg.htm

CDC "Talk With Your Doctor "campaign:
http://www.cdc.gov/tobacco/campaign/tips/groups/health-care-providers.html
With this new national campaign, you may find more patients asking you about how they can quit smoking. This site provides links to the science behind tobacco quitlines, frequently asked questions, posters, and free looped video for your office.

Pharmacology and Other Resources for Smoking Cessation

Clinical Guideline for Prescribing Pharmacotherapy for Smoking Cessation
(PDF, U.S. Department of Health and Human Services):
http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/prescrib.pdf

Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation
(PDF, American Academy of Family Physicians, 320KB):
http://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/pharmacologic-guide.pdf

Nicotine Replacement Therapy Labels May Change (Food and Drug Administration—FDA):
http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm345087.htm

Smoking Cessation Leadership Center, University of California San Francisco:
http://smokingcessationleadership.ucsf.edu/index.htm

To order quitline materials, please send a request (including mailing address) to: PCHClearinghouse@doh.wa.gov

Organizations

Tobacco Education Clearinghouse of California has a catalog of materials for general populations, pregnant and parenting women, and ethnicity/racial specific audiences. There is a charge for these materials. Contact Tobacco Education Clearinghouse of California to request a catalog by phone at 831-438-4822, ext.103 or ext.230, or by fax at 831-438-1442.

Websites

Washington State Sites

The Health of Washington State:
www.doh.wa.gov/DataandStatisticalReports/HealthofWashingtonStateReport.aspx
From the Table of Contents, go to "Major Risk and Protective Factors" for a tobacco link containing a variety of statistics.

Tobacco Prevention and Control:
www.doh.wa.gov/YouandYourFamily/IllnessandDisease/TobaccoRelated.aspx
Download the 2001 Report "Building a Solid Foundation for a Healthier Washington." Find information on secondhand smoke as well as pregnancy and smoking.

Secondhand Smoke and Washington State:
http://www.smokefreewashington.com/
A website promoting smokefree living environments in Washington State.

National/International Sites

Note: *Many of these websites have search engines specific to their site. In most cases, you can type the keyword "tobacco" in the search box for results relating to tobacco cessation.*

American Cancer Society: www.cancer.org

American College of Obstetricians and Gynecologists: www.acog.org

American Heart Association: www.heart.org/HEARTORG/

American Lung Association: www.lungusa.org

American Medical Association: www.ama-assn.org/

American Thoracic Society: www.thoracic.org

Campaign for Tobacco-Free Kids' Kick Butts Day: http://kickbuttsday.org/
Kick Butts Day is an annual initiative that encourages activism and leadership among elementary, middle and high school students

Centers for Disease Control Tobacco Information and Prevention Source:
www.cdc.gov/tobacco/

EPA Environmental Tobacco Smoke: www.epa.gov/smokefree/healtheffects.html

Health Care Education and Training, Inc.: www.hcet.org

Legacy for Longer Healthier Lives: www.legacyforhealth.org

March of Dimes Smoking, Alcohol, and Drugs Webpage:
http://www.marchofdimes.com/pregnancy/smoking-during-pregnancy.aspx

National Cancer Institute: www.cancer.gov

National Spit Tobacco Education Program:
www.oralhealthamerica.org/programs/nstep
Founded in 1994, NSTEP is an effort to educate the American public about the dangers of smokeless or spit tobacco.

QuitNet: www.quitnet.com/qnhomepage.aspx
Launched in 1995, QuitNet is a Web-based smoking cessation and resource forum funded by Massachusetts Tobacco Control Program.

Smoke-Free Families: http://smokefreefamilies.tobacco-cessation.org

United States Department of Health and Human Services:
www.healthfinder.gov

United States Public Health Service: Treating Tobacco Use and Dependence: 2008 Update: http://www.ahrq.gov/legacy/clinic/tobacco/tobaqrg.htm

World Health Organization: www.who.int/en/

Sites That Target Specific Populations

Ethnic/Racial Groups

Native CIRCLE: www.nativeamericanprograms.org/index-circle.html
The American Indian/Alaska Native Cancer Information Resource Center and Learning Exchange

Cross Cultural Health Care Program: www.xculture.org
Lists books, videos, articles, trainings on health issues of ethnic communities.

University of Washington Medical Center:
http://depts.washington.edu/pfes/CultureClues.htm
Tip sheets for clinicians designed to increase awareness about general concepts and preferences of patients from diverse cultures: Albanian, African American, Chinese, Korean, Latino, Russian, Vietnamese (not specific to tobacco).

Gay, Lesbian, Bisexual, Transgender People

Gay City Health Project: www.gaycity.org

Appendix G – Additional Reading

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For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TYY 711).